STATE OF CALIFORNIA

DEPARTMENT OF INSURANCE

PROPOSED DECISION

RH 003031326

In the Matter of: Proposed adoption of the Insurance Commissioner's regulations pertaining to pure premium rates for workers' compensation insurance, the California Workers' Compensation Uniform Statistical Reporting Plan—1995; the California Workers' Compensation Experience Rating Plan—1995; and the Miscellaneous Regulations for the Recording and Reporting of Data. These regulations will be effective on January 1, 2004.

A public hearing was held on the captioned matter at the time and place set forth in the Notice of Proposed Action and Notice of Public Hearing, File Number RH 03031326 dated July 30, 2003, which is included in the record. At the conclusion of that hearing, the hearing officer announced that the record would be kept open and the hearing would resume on September 29, 2003. A hearing was held on that day at the same location as the first hearing. At the conclusion of the September 29, 2003 hearing, the hearing officer announced that the record would stay open and a Notice would be sent out informing interested parties and the public of the date and time of the hearing. On October 10, 2003, a Second Notice of Hearing was sent out notifying interested parties that the third hearing on these matters would be held on November 3, 2003. A public hearing was held on that date.

The record discloses the persons and entities to whom or which the Notice was disseminated. The Notice summarized the proposed changes and recited that a summary of the information submitted by the Insurance Commissioner in connection with the proposed changes was available to the public. In addition, the "Filing Letter" dated July 30, 2003, submitted by the Workers' Compensation Insurance Rating Bureau of California (WCIRB) and related documents were available for inspection by the public at the San Francisco and Los Angeles offices of the Department of Insurance and were available online at the WCIRB website, wcirbonline.org.

Testimony, written and oral, was taken at hearings in San Francisco on September 12, 2003, September 29, 2003, and November 3, 2003 and exhibits were received into the record. The matter was submitted for decision at the conclusion of the last hearing. The matter having been duly heard and considered, the following Proposed Decision and Proposed Order are hereby made.

EXPLANATION AND HISTORY

The matters considered at the hearing consisted of proposed changes in the regulations of the Insurance Commissioner regarding workers' compensation pure premium rates, the Experience Rating Plan, the Uniform Statistical Reporting Plan and the Miscellaneous Regulations for the Recording and Reporting of Data. The new regulations will apply to new and renewal policies with anniversary rating dates on or after January 1, 2004.

The changes in the regulations were proposed to the Insurance Commissioner in a letter with attachments (the "Filing Letter") dated July 30, 2003, submitted by the Workers' Compensation Insurance Rating Bureau (WCIRB) of California, a licensed workers' compensation insurance rating organization.

The WCIRB's filing proposed pure premium rates that reflect insurer loss costs and loss adjustment expenses. In addition, the WCIRB has proposed amendments to the California Experience Rating Plan—1995, the Uniform Statistical Reporting Plan—1995, and the Miscellaneous Regulations for the Recording and Reporting of Data.

The WCIRB has also filed amendments to the United States Longshore and Harbor Workers Compensation Insurance Supplement to the California Workers' Compensation Uniform Statistical Reporting Plan—1995. These amendments, which have been adopted by the WCIRB pursuant to the authority of Insurance Code Section 11753.3, are for Department review only.

The Adopted Pure Premium and Its Determination

Pure premium rates approved by the Insurance Commissioner reflect only loss costs, including loss adjustment expenses; they do not include any provision for general expenses, commissions, other acquisition expenses, premium taxes, or profits. Although the commissioner's pure premium rates are not mandatory in themselves, provisions of AB 227 enacted in September of 2003 require that the reduction in pure premium that the commissioner has calculated is due to 2003 reform legislation must be reflected in insurer rate filings and that reduction must be passed through to policyholders.

The pure premium advisory rates proposed by the WCIRB in its July 30, 2003 letter would have been, on average, 12.0% higher than the pure premium rates that were approved effective July 1, 2003. These proposed rates were based on an analysis of the law that was existing as of the date of filing.

Workers' compensation reform legislation that was enacted after the WCIRB's filing will have a significant effect on pure premium rates beginning in 2004. After the September 12, 2003 hearing, the WCIRB considered the effect of the law changes and returned to the Department on September 29, 2003 with a revised proposal for pure premium rates. The pure premium advisory rates proposed by the WCIRB taking into account reform legislation were, on average a decrease of 2.9% from the rates effective on July 1, 2003.

For reasons detailed below, the Department adopts pure premium rates that include a decrease of 22.7% from the rates originally proposed by the WCIRB on July 30, 2003 and a decrease of 13.4% from the rates in effect on July 1, 2003 for new and renewal policies with anniversary rating dates on or after January 1, 2004. The pure premium rates adopted herein are based on the hearing testimony and an examination of all materials in the record by the hearing panel which included two of the Department's workers' compensation actuaries, Ronald Dahlquist and Eric Johnson.

Loss Development

In prior filings, the WCIRB has applied a trend to indemnity paid loss development factors, based on the exponential trend in the last three years. The Department rejected the use of the three-year trend and ordered the use of the five-year trend. In this filing, the WCIRB proposes dropping the trending and using the latest year. They say that the latest factors "are not significantly above those of the prior year."

The latest factors are actually slightly lower than those of the prior year. That being the case, there is clearly no justification for trending the factors and the WCIRB's recommendation to use the latest year is approved.

The WCIRB has in recent filings recommended using the three-year exponential trend in the medical paid loss development factors, and the Department has ordered the use of the five-year trend instead. The WCIRB in this filing proposes to continue using the three-year trend. The WCIRB says that the three-year trend period has been more accurate in the past, that it is supported by the more recent June 30 experience and that the indicators suggest continued deterioration. These indicators are the quarterly paid development factors, accident year claims settlement ratios, policy year ratios of open claims, ratios of paid losses to incurred losses and the percentages of serious claims.

The indicators all suggest continued upward movement in the paid medical development factors. They do not, however, provide definitive guidance whether to choose the three-year or the five-year trend. They also suggest continued upward movement in the paid indemnity development factors. As noted above, the indemnity factors themselves do not show upward movement.

In our last decision, we repeated that the proposed method crosses the line in the actuarial trade-off between stability and responsiveness and that the use of just three points to fit a curve is inherently unreliable and unsound.

For these reasons, we reject the use of the three-year trend and substitute the five-year trend.

In prior filings, the WCIRB has applied trending to paid loss development factors out to 87 months. In this filing the WCIRB proposes extending the trending for the medical factors out to 159 months. The WCIRB says that medical development between 87 and 159 months has escalated and is, for the most part, at an all-time high. They say trending

would have been more accurate and also point again to the indicators of settlement ratios and proportion of serious claims.

While the case for extending the trending out to 123 months is stronger than the case for extending it out to 159 months, we accept the WCIRB's recommendation.

Trending

In prior filings, the WCIRB trended the on-level pure premium ratios for indemnity. In this filing, the WCIRB proposes to use the average of the last three years. The WCIRB says that the recent experience has been flat. The WCIRB says that three-year average is more appropriate than the latest year because the latest year is relatively immature, thus volatile.

Ordinarily, we would be sympathetic to the WCIRB's argument in favor of the three-year average. We note, however, that, in its analysis of the effects of the 2002 reform legislation, AB 749, the WCIRB cut the trend in the on-level pure premium ratios but did not attempt to reflect any savings on indemnity. While there is no published research that we are aware of that quantifies the potential savings, our analysis shows that it is reasonable to expect some savings. In the absence of such a quantification, we look elsewhere for a less than perfect solution and the use of the latest year rather than the three-year average presents itself.

We therefore reject the use of the three-year average and substitute the latest year.

In prior filings, the WCIRB trended the on-level pure premium ratios for medical beginning with accident year 1993. In this filing, the WCIRB proposes beginning with accident year 1996. The WCIRB says that the 6% trend resulting from use of the longer period is not representative of the more recent data, that there was a fundamental shift in medical services in 1996, due to the Minniear decision, and that using the post-1995 period produces more accurate estimates. The WCIRB notes that the increase due to this change in method is partially offset by their adjustment for the partial repeal of the primary treating physician presumption in AB 749.

We have done a careful review of the 1993 reform legislation, AB 110, of the 1996 Minniear decision and of the 2002 reform, AB 749. We concur with the WCIRB that the Minniear decision, in clarifying that the treating physician presumption applied to all medical issues, not just impairment, significantly changed the claims environment. Therefore we allow the proposed change in the trending methodology for the medical on-level pure premium ratios.

Effect of Increased Indemnity Benefits on Medical Losses

As in prior filings, the WCIRB has included a loading for an increased utilization of medical benefits due to an increase in indemnity benefits. This loading has been 26% of

the percentage increase in indemnity benefits. In our last decision we explained our reasoning for rejecting the loading and we incorporate that discussion by reference.

In this filing, the WCIRB offers additional support for the loading and reduces the amount somewhat, to 18.9%. The additional support is a Spearman Rank Correlation between changes in indemnity frequency presumably due to utilization and changes in medical severity for non-cumulative claims for the years 1977 to 2000. The amount of the reduction from 26% to 18.9% is based on the adjustment to the severity in years with an indemnity benefit change necessary to reduce the correlation to zero, or as close as possible to zero. This adjustment is a factor of .944 or -5.6%.

It is reasonable to try to test the assumption that new indemnity claims are also new medical claims (rather than medical only claims) or that the medical severity on the new indemnity claims is similar to that of existing medical claims. The WCIRB's test appears to show that, in years where there is an indemnity benefit increase, there is a decrease in the overall average medical severity. Such a result is inconsistent with the use of the 26% load.

The question is whether the test is precise enough to establish the -5.6% as the right adjustment. We determine that the answer is no. We do an alternative, simpler comparison. The increase in medical severity in years without an increase in indemnity benefits is 14.1%; the increase in those years without an increase in benefit is 9.2%. A standard statistical test called a t-test shows that this difference of 4.9% is significant. Over the years considered, the average increase in indemnity frequency due a benefit change is 2.0%.

Based on this analysis, we reject in its entirety the load for increased medical utilization due to an indemnity benefit increase.

Provision for Earthquake Exposure

In this filing, for the first time, the WCIRB includes a loading for the expected average annual losses arising from earthquakes. The amount of 1.8% is based on modeling by the EQECat firm.

Actuarial standards of practice require, among other things, that the output of such a model be evaluated for reasonableness. One of the factors to consider in that validation is "how historical observations, if applicable, compare to results produced by the model". The 90^{th} percentile expected loss from the model is $1 billion, that is, in any given year there is a 10% chance of a loss at least this large. While the significant growth in the California workers compensation market, due to the increase in the size of the work force and in particular the inflation in medical costs, makes direct comparison with historical observations difficult, the simple truth is that in the nearly 90-year history of the workers compensation system, no loss of anywhere near this size has ever occurred.

The 99th percentile expected loss from the model is $5.7 billion. Even a much smaller loss would quickly deplete the surplus of the companies writing more than half of the market. No mechanism exists for setting aside the proceeds from the WCIRB's proposed earthquake loading and ensuring that they will always be available to pay earthquake-related claims.

For these reasons, we reject the earthquake load.

Wage Forecast

In prior filings, the WCIRB used a wage forecast based on Global Insight's employment cost index for the western United States. In this filing, the WCIRB proposes to use a wage forecast from UCLA's Anderson School of Business. The WCIRB says that the Anderson forecast is a qualitatively better measure the Global Insight index because it reflects changes in the mix of occupations and that it is California-specific.
The WCIRB also says that the Anderson forecast is at least as stable as the Global Insight index, and that it is more highly correlated with actual changes in insured payroll than other indices that were reviewed.

The WCIRB also notes that UCLA forecasts lower short-term growth.The change was made to address concerns the Department had previously raised and we accept the WCIRB's recommendation.

Allocated Loss Adjustment Expense

The WCIRB uses an average of two development methods to project allocated loss adjustment expense (ALAE). The first method is to develop paid ALAE; the second is to develop the ratios of paid LAE to paid indemnity. For both development methods, the WCIRB has in past filings used the average of all the factors excluding the highest and lowest. The WCIRB now proposes the latest year's factor. The WCIRB says that paid ALAE development is slower when there is paid loss development and decreasing claim settlement ratios.

Given the large volume of data available, there seems little necessity for using a long-term average. Nor does there appear to be so much volatility as to require excluding the high and low factors. Given that, the choice would then be between using a short-term average, the latest year or, possibly, trending, as is done with paid medical. We note that, with only a few exceptions, the factors out to 135 months are increasing.

We therefore accept the WCIRB's recommendation to use the latest year.

For both development methods , the WCIRB has in past filings applied an exponential curve to the post-1992 data. For the paid ALAE development method, the WCIRB now proposes to use the average of the last three years. The WCIRB says that the developed ratios for the last several years have been relatively flat. For the paid ALAE to paid indemnity development method, the WCIRB proposes to continue using the post-1992

exponential trend. The exponential trend produces an extraordinarily high forecasted ratio of ALAE to indemnity, 30.4%. We note the coefficient of determination for a linear trend is virtually identical to that for the exponential trend and that linear trend produces a value, 27.2%, that appears on its face to be as reasonable.

Because the proposed change for the first development method represents a significant reduction in itself, we accept the WCIRB's proposal for both development methods.

2003 Reform Legislation

ITEMS AFFECTING FEE SCHEDULES

Physicians Fees (Official Medical Fee Schedule):

The legislation establishes that the existing official medical fee schedule rates for physician services shall be reduced by 5% for services performed in 2004 and 2005. The Administrative Director of the Division of Workers Compensation has been given the authority to establish a fee schedule beginning on January 1, 2006. If the Administrative Director does not establish a new schedule on that date, the currently existing schedule will apply until the Director establishes a schedule.

The WCIRB evaluates the impact of this element of the reform legislation as a 0.3% decrease in overall pure premium rate level. We agree with the methods and assumptions used to arrive at this conclusion, and approve the 0.3% decrease effect.

Inpatient Hospital Fees:

The reform legislation sets maximum reasonable inpatient hospital fees at 120% of Medicare fees, effective from January 1, 2004 until such time as the Administrative Director of the Division of Workers Compensation adopts an official fee schedule.

The WCIRB, using the results of a detailed CHSWC study of inpatient hospital fees, evaluates the impact of this element of the reform legislation as a 0.5% increase in overall pure premium rate level. We agree with the methods and assumptions used to arrive at this conclusion, and approve the 0.5% increase effect.

Pharmaceutical Fees:

The reform legislation established a schedule for pharmaceuticals based on 100% of the Medi-Cal Schedule.

The WCIRB, using the results of a CHSWC study of pharmaceutical fees, evaluates the impact of this element of the reform legislation as a decrease of approximately 37% in pharmaceutical costs, for a 1.6% decrease in overall pure premium rate level. The WCIRB points out, however, that its previous filing attributed an 18% reduction in total pharmaceutical costs, or a 1.0% decrease in overall costs, to provisions of AB 749 that

would encourage the use of pharmacy networks. These savings have not materialized, causing the pure premium rate level to be understated by this amount. The net effect on the indicated pure premium rate level is a 1.0% decrease.

We agree with the methods and assumptions used to arrive at this conclusion. We also note that the savings due to the provisions of AB 749 that have not been implemented would likely overlap with the savings generated by the new fee schedule. This means that, if the pharmacy networks envisioned in AB 749 would be instituted, they would not be likely to generate significant additional savings. We approve the 1.0% decrease effect.

Outpatient Facility Fees

The reform legislation establishes that the maximum facility fee for services performed at an ambulatory surgery center may not exceed 120% of the Medicare fee for the same service performed in a hospital outpatient facility.

The WCIRB, using the results of a detailed CHSWC study of outpatient hospital fees, evaluates the impact of this element of the reform legislation as a 4.1% decrease in overall pure premium rate level.

We note that the WCIRB assumes that outpatient facility fees represent 10% of total benefit costs, based on an estimated 60-40 split between outpatient and inpatient costs. We note that there is uncertainty with regard to this split: it is possible that outpatient costs, which have been growing rapidly in recent years, may exceed 60% of the total of inpatient and outpatient fees. We also note that the WCIRB does not assume any utilization impacts as a result of the imposition of a fee structure for outpatient facility fees, although there is a significant possibility that there will be a shift back to inpatient services as a result of the legislation.

After these considerations, we agree with the methods and assumptions used to arrive at this conclusion, and approve the 4.1% decrease effect.

ITEMS AFFECTING MEDICAL UTILIZATION

Limitations on Chiropractic Visits

The reform legislation has established a limit of 24 chiropractic visits for the life of a claim.

The WCIRB concludes that the 24 visit limit will reduce chiropractic costs by 40%, which will result in reduction of the overall pure premium rate level by 2.2%. Key assumptions are that chiropractic costs are 5.4% of overall costs; that a strict application of the 24 visit limit would produce a 50% savings on chiropractic costs; and that up to 20% of these potential savings will be lost due to exceptions approved by employers and due to shifting to physical therapy treatments in some cases to maintain treatment despite the limits.

We note from our review of the ICIS data on chiropractic costs, both unlimited and limited to 24 visits, that there are clear trends in the data. The percentages of chiropractic costs eliminated by the 24 visit limit appear to increase as an individual accident year matures. Furthermore, the percentages appear to increase from one accident year to the next, for each given stage of development. Even taking into account the lack of complete coding before 1999, it seems entirely possible that the ultimate percentage of chiropractic costs eliminated could be 60% or more. We are also skeptical that the loss of savings due to exceptions and switching to physical therapy services will be as high as 20%.

We note, however, that there is a lack of sufficient data on chiropractic and physical therapy costs in California workers compensation, and that there is a lack of consistency between the data sources that are available to the WCIRB. The Bureau should make a credible attempt to balance the data from the sources it does have, and should pursue more accurate and complete data sources in this area.

Given the data limitations, and the fact that the 2.2% overall reduction in pure premium rate level due to this reform item is very significant, we are reluctant to attribute a larger reduction effect. Accordingly, we approve the 2.2% overall reduction in pure premium rate level due to the 24 visit limit on chiropractic services.

Limitations on Physical Therapy Visits

The reform legislation has established a limit of 24 physical therapy visits for the life of a claim.

The WCIRB concludes that the 24 visit limit will reduce physical therapy costs by 40%, which will result in reduction of the overall pure premium rate level by 1.5%.

Key assumptions are that chiropractic costs are 3.8% of overall costs; and that a strict application of the 24 visit limit would produce a 50% savings on chiropractic costs. Due to a belief that actual physical therapy costs are significantly higher than what has been measured in the data available to the WCIRB, no offset has been made for potential loss of savings due to exceptions approved by employers or cost shifting between treatment types.

Given the data limitations, we will accept the WCIRB analysis and approve the 1.5% overall reduction in pure premium rate level due to the 24 visit limit on physical therapy services. As with chiropractic services, we direct the WCIRB to pursue more accurate and complete data sources for physical therapy costs.

ACOEM Medical Treatment Utilization Guidelines

The reform legislation directs the Administrative Director of the Division of Workers Compensation to establish an Official Medical Treatment Utilization Schedule by December 1, 2004. In the interim, the standards contained in the updated version of the

American College of Occupational and Environmental Medicine (ACOEM) Practice Guidelines are to be presumed to be correct with respect to the issue of the extent and scope of medical treatment. This presumption goes into effect three months after the publication of the new guidelines.

The WCIRB was unable to decide on a single estimate of the impact the ACOEM Guidelines will have on the overall pure premium rate level. Reflecting a split on its Actuarial Committee as well as its Governing Committee, the WCIRB has filed a range of savings effects from 0%, or no effect, to -2.5%.

The WCIRB, in assessing the impact of the Guidelines, agreed that the Guidelines have the "potential to dramatically impact costs." By this statement it is reasonable to assume that the WCIRB agrees that the Guidelines could produce substantial savings. The Bureau's reluctance to reflect significant savings in the pure premium rates appears to be based on several considerations: that the implementation date of the Guidelines is uncertain; that substantial assumed savings due to AB 749's repeal of the primary treating physician presumption have already been factored into the pure premium rates and may not be realized; that substantial additional savings for the reform legislation's limits on chiropractic and physical therapy visits have been factored into the pure premium rates in this filing; that the Guidelines' legal presumption of correctness will prove to be easily overcome; and finally, that the cumulative effect of savings due to all reforms assumed in this and recent filings is both substantial and significantly uncertain, and that prudence should dictate that a large effect for the Guidelines should not be assumed and factored into the pure premium rates until the degree of uncertainty is significantly reduced with the passage of time and the emergence of real cost data under the new laws.

Considerations Regarding the Implementation Date

We have received testimony that the ACOEM Guidelines are due to be published by January 1, 2004. If this schedule is met, they would be implemented on April 1. We do not believe it would be reasonable to assume that publication would be delayed by more than three months, so we would expect the Guidelines to be in effect no later than July 1.

We do not believe, however, that the uncertainty in the implementation date will have a significant impact on the savings to be realized on policies effective in 2004. We note that approximately one thirty-second of policy year 2004's premium will be earned by April 1, and about one eighth of its premium will be earned by July 1. We also note that many claims will be open for years after the date of injury, so considerably less than 10% of all medical services performed on injured workers covered by these policies will be performed before the Guidelines take effect.

Considerations Regarding the Magnitude of Savings

Based on the testimony we have received, it appears that most of the knowledgeable participants in this process agree that the Guidelines have significant potential to produce

substantial reductions in California workers compensation medical costs, if they are allowed to apply as intended. This potential seems clear from the testimony of Dr. Jeffrey Harris, one of the principal authors of the Guidelines. Written statements from the WCIRB and from CHSWC support this contention.

The only substantive testimony we have regarding the possible magnitude of savings is the study dated October 20, 2003, prepared for CHSWC by Frank Neuhauser of the UC DATA/Survey Research Center. Our conclusions are based on reasoning that is similar to that of this study. Accordingly, the following discussion outlines his rationale and how our logic follows his logic or departs from it.

Mr. Neuhauser's study first addresses the question of what "premium" in excess of group health managed care is currently paid in California workers compensation. Based on a review of a number of detailed studies in a number of states, he concludes that his central estimate of the "premium" is 150%, with a range of from 100% to 200%. This appears to be reasonably well supported, and we agree with it. The resulting percentages of California workers compensation medical costs that represent excess costs above group health are 60% at the midpoint, with a range of from 50% to 66-2/3%. We select the midpoint of 60% as the most appropriate value.

Second, Mr. Neuhauser concludes that the average pricing premium in California workers compensation is 22%. This is based on a number of studies that estimate the California workers compensation pricing premium for separate components of medical costs. The resulting percentages of California workers compensation medical costs that represent excess costs due to over-utilization are 50.4% at the midpoint, with a range of from 37% to 59.4%.

We note that Mr. Neuhauser's analysis measures the price differential relative to Medicare fee schedules where possible. We believe an adjustment should be made to recognize that fee-for-service plans in Group Health are typically priced somewhat higher than Medicare, so we assume instead that the average pricing premium is 12%. This yields a value of 55.2% as the percentage of California workers compensation medical costs that represent excess costs due to over-utilization, rather than Mr. Neuhauser's 50.4%.

The third step is the key step, and appears to involve a key extrapolation. Specifically, Mr. Neuhauser appears to rely on a number of studies of cost savings attributed to the application of guidelines to specific injuries and treatments, and assumes that cost savings on all other injuries and treatments will be similar. While the conclusion seems reasonable, it would seem obvious that there is a great deal of uncertainty in this step in the process. The result of this step is a presumption that over-utilization can be reduced by between 50% and 90%, with a midpoint of 78.6%. This translates to a reduction of California workers compensation medical costs by between 19.0% and 53.3%, with a midpoint of 39.6%.

While we have received much testimony supporting the contention that the ACOEM Guidelines have the potential to substantially reduce unnecessary medical treatment of injuries in the California workers compensation arena, we are not comfortable assuming in advance of implementation that over three quarters of such unnecessary medical treatment cost can be eliminated. We have heard that the Guidelines would have their maximum effect in a managed care setting, accompanied by such administrative aids as mandatory dispute resolution, contractually defined services with some procedures excluded from coverage, insurer control of which providers are allowed to provide services, and the use of deductibles and co-payments. We realize that none of these cost controls will be present in the environment when the Guidelines are implemented. We do note that Mr. Neuhauser's reference point is the level of costs under Group Health fee-for-service plans, so that comparisons with cost savings attributable to the managed care environment are not germane to this discussion. We do note that some of these elements are also present in the fee-for-service arena, so it seems reasonable to assume that the percentage of excess California workers compensation medical costs that could be eliminated by fully effective Guidelines should be significantly less than 100%. Based on all of these considerations, we select two-thirds, or 66-2/3%, as our assumption. This translates to a reduction of California workers compensation medical costs by 36.8%, if the Guidelines were fully effective.

Considerations Regarding the Strength of the Legislation

In his fourth step, Mr. Neuhauser determines that the legislation is strong, and requires a substantial effort to meet its burden of proof in order to overcome its presumption of correctness. He bases this conclusion on the legal analysis prepared by Judge Mark Kahn and included in his report. He states that Judge Kahn's interpretation is consistent with the opinions expressed by Judge Joel Gomberg, who testified in the September 29 Hearing, and by Chief Judge Steve Siemers. Accordingly, Mr. Neuhauser makes no reduction in his estimates to account for the possibility that the Guidelines will ever be successfully challenged.

It is our opinion that it is overly optimistic to assume that no adjustment needs to be made for the possibility that the Guidelines may not be applied fully to every case, that exceptions to the Guidelines may be granted with some regularity, or that the Guidelines might even be overturned on a precedent-setting appeal.

We have heard the opposing viewpoint, in the form of assertions by some that the presumption of correctness afforded the Guidelines under the reform legislation can fairly easily be overcome. The argument is that testimony that treatment outside the guidelines is necessary to "cure and relieve" the worker's injury will be sufficient to accomplish this. The conclusion of proponents of this argument is that no savings due to the Guidelines should be built into the pure premium rates.

We believe it is appropriate to give some weight to both opposing arguments. We are convinced that, as Judge Kahn has testified, many judges will view the presumption to be strong, and will welcome the opportunity to deny treatment that is outside the Guidelines

and appears to be excessive and unnecessary. At the same time, we fully expect that some judges will take a different view, and will grant exceptions with some frequency. Further, we cannot dismiss out of hand the possibility that a court decision could defeat the Guidelines entirely, despite the clear legislative intent behind the reform legislation. The Minnear Decision is a clear example of a court decision that significantly expanded the scope of reform legislation, and that ultimately led to significant additional costs to the California workers compensation system.

We conclude that a 50% reduction in the savings estimates due to uncertainties in the legal environment is appropriate. This translates to a reduction of California workers compensation medical costs by 18.4%, if the Guidelines were implemented on time, and not considering offsets for utilization savings already accounted for in the measurement of other reform items, both in this year's legislation and in AB 749.

Considerations Regarding the Savings attributed to the AB 749 Repeal of the Primary Treating Physician's Presumption , and the Caps on Chiropractic and Physical Therapy visits

In his fifth step, Mr. Neuhauser reduces his savings estimates to avoid double-counting the savings attributable to the 24-visit limitation on chiropractic and physical therapy visits enacted in the new reform legislation.

Mr. Neuhauser excludes chiropractic and physical therapy costs, which amount to 11.8% of total medical costs, from his savings calculations. He does this because the WCIRB has already reflected savings for 24-visit limitations. He recognizes that this approach has two potential sources of inaccuracy. The first is that it may overstate the Guidelines' potential to obtain savings on costs of medical services other than chiropractic and physical therapy, because it assumes that all services are subject to the same degree of over-utilization. There is clear evidence that chiropractic and physical therapy services are over-utilized to a greater degree than are most other medical services. On the other hand, the Guidelines clearly will limit chiropractic and physical therapy treatments to a greater degree than will the 24-visit limitations alone. This will underestimate the savings on chiropractic and physical therapy costs.

Mr. Neuhauser assumes that these inaccuracies will offset each other. In the absence of specific data to measure the separate effects, we believe this assumption is reasonable.

It would appear that Mr. Neuhauser's estimate of savings due to the Guidelines would be 34.9% of medical losses after this step. Our estimate, before considering the overlap with AB 749's repeal of the primary treating physician presumption and the effect of delayed implementation of the Guidelines, would be a reduction of 16.2%.

In his sixth step, Mr. Neuhauser reduces his savings estimates to avoid double-counting the savings attributable to the repeal of the primary treating physician's presumption in AB 749. He first observes that the WCIRB filing contains a reduction in medical loss trend that equates to an approximate 7% reduction in medical losses for policy year 2004.

He chooses to reflect this by reducing his original estimate of the portion of the differential in cost that is attributable to over-utilization by 7%.

We agree that the repeal of the primary treating physician's presumption in AB 749 was intended to address over-utilization of medical services in California workers compensation, and that implementation of the ACOEM Guidelines in this year's reform legislation is intended to do the same thing. If it were not for the delayed implementation of the Guidelines, we would expect that there would be almost complete overlap, because we would expect the ACOEM Guidelines to eliminate all of the same costs eliminated by the repeal of the primary treating physician's presumption, and some fairly significant additional costs as well. This is because the repeal of the primary treating physician's presumption simply allows for the opposing physician's opinion and evidence to receive roughly equal weight in legal proceedings, while the Guidelines provide a set of rules for the treating doctor to follow.

We observe that the WCIRB methodology applies a 7.4% reduction to all medical losses. The WCIRB has, in effect, assumed that 7.4% of all medical losses will be eliminated as a result of the repeal of the primary treating physician's presumption. We would expect total medical losses to be the appropriate base for estimation of the overlap effect to be subtracted. Our estimation process does this, and results in a significant difference with Mr. Neuhauser's estimates.

There is some debate as to whether the WCIRB's estimate of this impact is overestimated. We note that the accuracy of this estimation is not particularly at issue here; what matters is that the WCIRB has reduced its estimates by this amount. We are attempting to avoid double-counting savings estimates that have already been accounted for in the ratemaking calculation. The 7.4% estimate is the one that has been accounted for in the ratemaking calculation, whether or not it is accurate, so it is the one that needs to be removed.

After this step, it can be inferred that Mr. Neuhauser's methodology would yield a midpoint estimate of approximately 32.5% in savings. Our corresponding estimate would be savings of approximately 8.8% of total medical losses, arrived at by subtracting 7.4% from our estimate after Step Five of 16.2%. It should be noted that our offset for the impact of the repeal of the primary treating physician's presumption will be reduced in the next step to account for the delay in implementation of the Guidelines.

In his seventh and final step, Mr. Neuhauser reduces his savings estimates account for the delay in implementation of the Guidelines and to recognize that the Guidelines will never be likely to provide complete coverage of all medical procedures. He reasons that all of the anticipated payments in calendar year 2004 on accident year 2004 injuries should be assumed to be paid outside the Guidelines, as should 30% of anticipated payments in calendar year 2005 on accident year 2004 injuries. Together, these payments are assumed to make up 16% of total payments on accident year 2004 injuries. To reflect the assumption that the Guidelines will never cover all procedures, he assumes that another

7% of all payments on accident year 2004 injuries should be assumed to be paid outside the Guidelines, bringing the total to 23%.

Mr. Neuhauser's final midpoint estimate of the rate level savings due to the implementation of the ACOEM Guidelines is 22.5% of total medical losses.

We agree that this rationale is reasonable; however, we note that it is keyed to accident year 2004, while the advisory pure premium rates that are the subject of this filing will be in effect for policy year 2004. Accordingly, we have modified Mr. Neuhauser's assumption, and assume that a total of 15% of policy year 2004's medical payments will be outside the guidelines: 8% due to the delayed implementation, and 7% due to the assumed incomplete coverage. We also reduce our offset for the impact of the repeal of the primary treating physician's presumption to account for the delay in implementation of the Guidelines, since we assume that there will be a period of time during which the repeal will be in effect and the Guidelines will not.

Our final midpoint estimate of the rate level savings due to the implementation of the ACOEM Guidelines is 7.18% of total medical losses, or 4.3% of total workers' compensation losses.

OTHER ITEMS

Vocational Rehabilitation Changes

The reform legislation repeals the existing vocational rehabilitation benefits and substitutes an educational voucher system. This system would provide vouchers to injured workers who are not back at work within 60 days after the termination of temporary disability payments and have not received a qualified offer of modified work. The size of the voucher varies with the severity of the injury.

The WCIRB estimates the effect of the elimination of the existing vocational rehabilitation system as a 5.8% decrease in the advisory pure premium rates. This is simply equal to the Bureau's estimate of vocational rehabilitation benefits as a percentage of total workers compensation benefits.

The WCIRB estimates the cost of the vouchers as 0.8% of the overall pure premium rate level. This is based on the size of the vouchers for each injury type, the distribution of injury types, and an overall assumption that one eighth of injured workers with permanent partial disability will receive the vouchers. This overall assumption is based on the expectation that one quarter of all injured employees with permanent partial disability will not return to work, and that half of these will not be eligible for the vouchers because they had been offered a return to work and had rejected the offer. The WCIRB relied on a Rand Institute study on permanent disability to draw this conclusion.

The WCIRB evaluates the net impact of these two elements of the reform legislation as a 5.0% decrease in overall pure premium rate level. We agree with the methods and assumptions used to arrive at this conclusion, and approve the 5.0% decrease effect.

Second Opinions on Spinal Surgeries

After considering the reform provisions allowing a second opinion by a qualified medical examiner when there is a dispute over the need for spinal surgery, we conclude that there is insufficient basis to establish an estimate of savings due to this provision. We agree with the WCIRB's contention that the timeframes in which a second opinion must be obtained may be unrealistically short.

Fraud Provisions

While we agree that the anti-fraud provisions of the reform legislation should have a beneficial effect, we are unable to determine an estimate of savings due to this provision. We do believe that the anti-fraud provisions will increase the likelihood that the other provisions, especially the ACOEM Guidelines, will have their intended effect.

Overall Reform Effect

The overall pure premium rate level impact of the reform legislation enacted in Assembly Bill 227 and Senate Bill 228 is -16.6% by our evaluation.

Overall Pure Premium Rate Level Effect

The WCIRB's original filing proposed a 12% increase in rates on January 1, 2004. Rather than this 12% increase, the 16.6% reduction due to the reforms decreases the pure premium rates by 6.7%. The differences in methodology detailed above result in a additional decrease of 7.3% from the WCIRB's proposed pure premium rates. The final result is a 13.4% decrease in the overall pure premium rate level.

Mandatory Rate Reductions

AB 227 requires all California workers' compensation insurers to submit a rate filing for policies incepting on or after January 1, 2004. Furthermore, that filing must contain a reduction of at least 6.7% from the insurers' current rates in order to comply with Insurance Code Section 11732. The rate filing must certify in the manner determined by the commissioner that rates reflect the cost savings contained in AB 227 and SB 228. The rate reduction must be passed through to policyholders and reflected in their final rates. Insurers that adopt the 6.7% or greater pure premium rate reduction with no additional changes or offsets will be granted an early effective date of January 1, 2004, for all filings received prior to that date, and the 30 day waiting period will be waived.

Future WCIRB Studies

The reform legislation embodied in Assembly Bill 227 and Senate Bill 228 has made substantial changes to the California workers compensation system. Significant cost reductions are expected, and are reflected in this Proposed Decision. At the same time, there is considerable uncertainty in the savings estimates attributed to the reforms. In the face of this uncertainty, it is critically important that the experience post-reform be closely monitored and studied to determine as promptly as possible to what extent the intended effects of the reforms are being realized. Prompt recognition of the actual effects of the reforms will allow pure premium rates to be adjusted appropriately so that additional savings can be passed on to employers as they materialize. Prompt recognition will also allow corrective legislation or other reforms to be enacted promptly to assure that the intent of the legislature to reduce California workers compensation costs can be realized.

Accordingly, the WCIRB is charged with establishing as soon as possible a thorough, in-depth, ongoing study of the effects of the reforms on the actual experience, with special emphasis on the effects of the implementation of the ACOEM Guidelines. This study should include individual case reviews of a large number of claim files, with special attention being given to the application of the Guidelines and their interpretation by workers compensation judges. A similar review of pre-reform cases should be reviewed in order to establish the extent of medical treatment in the pre-reform environment.

Continuation of Existing WCIRB Studies

In prior advisory pure premium filing decisions, we have directed the WCIRB to perform the following studies:

1. Monitoring of the Utilization Impact on Claim Frequency
2. Monitoring the Impact of the Change in Primary Treating Physician Presumption
3. Monitoring the Impact of AB 749 Changes with Respect to Pharmaceuticals
4. Evaluating the Cost Impact of Pharmaceutical and Outpatient Fee Schedules
5. Evaluating the AB 749 Changes Related to Health Care Organizations
6. Evaluation of Other Cost Provisions of AB 749
7. Wage Forecasting Methodologies
8. Analysis of Experience of Deductible Policies
9. Analysis of Long-Term Loss Development
10. Analysis of the Cost of Medical Cost Containment Programs

Of these studies, number 7 has been completed and number 4 has been superceded by this year's reform legislation. While ongoing monitoring of this year's reform legislation and evaluation of legislation that is likely to be proposed over the next months must take higher priority, we remind the WCIRB that we expect them to make progress on these studies as well.

Classification Relativities

The overall change in pure premium rates is an indicated average change over the approximately 500 industry classifications in California. The specific pure premium rate for each industry classification is determined both by the average or overall change in pure premium rates and the estimated change in each classification's relative share of the total statewide losses. Each classification's relativity is based on the claim and payroll experience of employers assigned to that classification compared to the claim and payroll experience of employers assigned to other classifications.

The proposed changes in relativities are appropriate and are adopted.

OTHER MATTERS

Amendments to the California Workers' Compensation Uniform Statistical Reporting Plan—1995

The WCIRB has proposed numerous amendments to the Workers' Compensation Uniform Statistical Reporting Plan—1995. All will take effect on January 1, 2004 and will be effective on new and renewal policies with anniversary rating dates on or after January 1, 2004. The WCIRB's proposed changes to the Uniform Statistical Reporting Plan—1995 are appropriate and are adopted, with the exceptions noted below:

Physical Audit Threshold

The WCIRB initially recommended that the physical audit threshold be increased from $12,000 to $21,000 to reflect, in part, the estimated policy year 2004 premium levels. However, when the WCIRB made a subsequent filing including the effect of reform legislation, it changed the recommended threshold to $18,000 based on its new recommended decrease in pure premium rates of –2.9%. However, the commissioner has approved a decrease in pure premium rates of –14.9% and the corresponding physical audit threshold must be changed to reflect those rates. The physical audit threshold is therefore increased from $12,000 to $16, 000.

Combining the Residential Cleaning Services Class with the Janitorial Services Class

The Maid Service Coalition has requested that the residential cleaning services classification, class code 9096 be combined with the janitorial services classification, code 9008. The Pacific Association of Building Service Contractors (PABSCO) oppose combining. The WCIRB considered this request and has determined that there is actuarial justification for continuing code 9008 and thus has not requested a change.

The WCIRB has proposed a classification relativity of 22.8896 for class 9096 and 16.262 for class 9008. The effect of combining the classes would be a class relativity slightly higher than 16.262, since the bulk of the payroll is in class 9008.

The Maid Service Coalition says that some residential cleaning services providers improperly report their payroll as janitorial services, and that other providers go uninsured, with the result that the class 9096 rates are computed based on less than 10% of the actual residential cleaning payroll. The Maid Service Coalition also says that there is much commonality between the work of the two classes.

The WCIRB and the PABSCO say that the basic criteria for having separate classes are present. These criteria are that the operations are clearly identifiable and relatively homogeneous and that the class develops sufficient data for credibility. PABSCO points also to dissimilarities in the work, including that the residential cleaners travel to and work at multiple sites while the janitors work at a fixed site, that janitors have more supervision leading to safer work habits and that the average wage for janitors is 28% higher than that for residential cleaners.

We do not believe that it would be appropriate to combine the two classes. While there may well be a major problem with mis-reporting and lack of insurance in the residential cleaning industry, combining the classes is not the appropriate solution.

There was testimony at the November 3, 2003 hearing indicating that at present only one insurer other than the State Compensation Insurance Fund is willing to write class 9096. It is clear to us that artificially suppressing the rate is not the way to increase availability of coverage for residential cleaners.

Amendments to the Miscellaneous Regulations for the Recording and Reporting of Data

The WCIRB has proposed changes in the Miscellaneous Regulations for the Recording and Reporting of Data which are editorial in nature. No public comments were received regarding these proposal amendments. The changes are appropriate and are adopted.

Amendments to the California Experience Rating Plan—1995

The WCIRB has proposed amendments to the California Experience Rating Plan—1995 to be effective on January 1, 2004. All of the proposed amendments are appropriate and are adopted, with the exception of the following:

Experience Rating Eligibility Threshold

Included in the WCIRB's initial filing is an increase in the experience rating eligibility threshold that reflected the proposed increase in pure premium. The purpose of the increase was to maintain approximately the same volume of experience rated employers. However, instead of an increase in pure premium rates, a decrease is now indicated. The

WCIRB is directed to revise the eligibility threshold to reflect the pure premium decrease approved by the insurance commissioner.

Insolvent Insurer Experience

The problem of how to provide experience modifications to eligible employers whose workers' compensation insurers have become insolvent has been an extremely difficult one to solve. Insolvent insurers typically either do not report the necessary data or provide data that is not of sufficient quality to be credible. Most insolvent insurers are currently not reporting data and will never report it. The Department and the WCIRB have discussed alternate procedures for addressing these concerns that would allow individual insurers to provide credits and debits equivalent to an experience modification in certain circumstances.
The WCIRB is directed to draft as soon as possible an advisory plan that would apply to previously rated risks that are not eligible for experience rating due to a lack of data from an insolvent insurer. This plan should allow an insurer to modify the premium charged to a qualified policyholder, either up or down, to reflect the experience developed by the policyholder. The WCIRB should consult with Department staff and with the public members of the WCIRB governing committee in developing this advisory plan.

Once the WCIRB's advisory plan has been reviewed and approved by the Department, insurers will be free to file the advisory plan as an amendment to their company rate filings and the plan will be considered approved upon filing with CDI's Rate Filing Bureau. No independent actuarial support will be required if an insurer files the plan approved by the Department and there are no other changes to the insurer's rating plan filed at the same time.

The advisory plan developed by the WCIRB and approved by the Department will only apply to risks that are not subject to the uniform experience rating plan as a result of a lack of data from an insolvent insurer. In order to apply the advisory plan and adjust premium at policy inception, there must be certainty regarding the applicability of the uniform plan. The WCIRB's proposed changes to Section III, Rule 3(f) of the Experience Rating Plan, which excludes the experience from insolvent insurers in most cases, does provide the required certainty and is adopted.

The WCIRB's original proposed changes to Section V, Rule 7 represent one approach to solving this problem, but have basic flaws. It is not clear that employers would ever be able to produce the necessary data to take advantage of the process set up by this proposed rule. Instead, we adopt the rule proposed in the WCIRB's letter of October 31, 2003:

Section V—Application of Experience Modification
7. **Experience Modifications ~~Computed Without~~ <u>That Exclude</u> Data From An Insolvent Insurer.** An experience modification ~~computed without~~ <u>that excludes</u> experience data described in Section III, Rule 3(f) shall not be published after the effective date of the experience modification unless~~:~~

~~a. The WCIRB was advised in writing by the liquidator or regulator prior to the effective date of the experience modification that data would not be sumbitted for the insolvent insurer, or~~

b. ~~T~~the experience modification is a revision to a previously published experience modification.

Plan Not Subject to Department Approval

United States Longshore and Harbor Workers' Compensation Insurance Supplement to the Uniform Statistical Reporting Plan

The WCIRB has adopted changes that are not subject to Department approval. However, we note that they are an appropriate addition to the USRP.

PROPOSED ORDER

WHEREFORE, IT IS ORDERED, by virtue of the authority vested in the Insurance Commissioner by California Insurance Code Sections 11734, 11750, 11750.3, 11751.5, and 11751.8 that Sections 2318.6 , 2353.1, and 2354 of Title 10 of the California Code of Regulations are hereby amended and modified in the respects specified herein.

IT IS FURTHER ORDERED that these regulations shall be effective January 1, 2004 for all new and renewal policies with anniversary rating dates on or after that date.

I HEREBY CERTIFY that the foregoing constitutes my Proposed Decision and Proposed Order in the above entitled matter as a result of the hearings held before the Department of Insurance on September 12 ,29, and November 3, 2003, and I hereby recommend its adoption as the Decision and Order of the Insurance Commissioner of the State of California.

November 7, 2003

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Larry C. White
Senior Staff Counsel